



VIRGINIA EPIDEMIOLOGY BULLETIN

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Editor: Carl W. Armstrong, M.D.

August, 1987

Volume 87, Number 8

Human Ehrlichiosis in Virginia?

Organisms of the genus *Ehrlichia* comprise a group of tickborne rickettsiae distinguished by their ability to parasitize the white blood cells of their host (1). These organisms were known previously to be pathogenic for wild and domestic animals, and one species, *E. sennetsu*, was known to cause an infectious mononucleosis-like syndrome among humans in Asia (1,2). Recently, the first well documented report of human illness caused by another *Ehrlichia* organism, *E. canis*, was described in the United States (3).

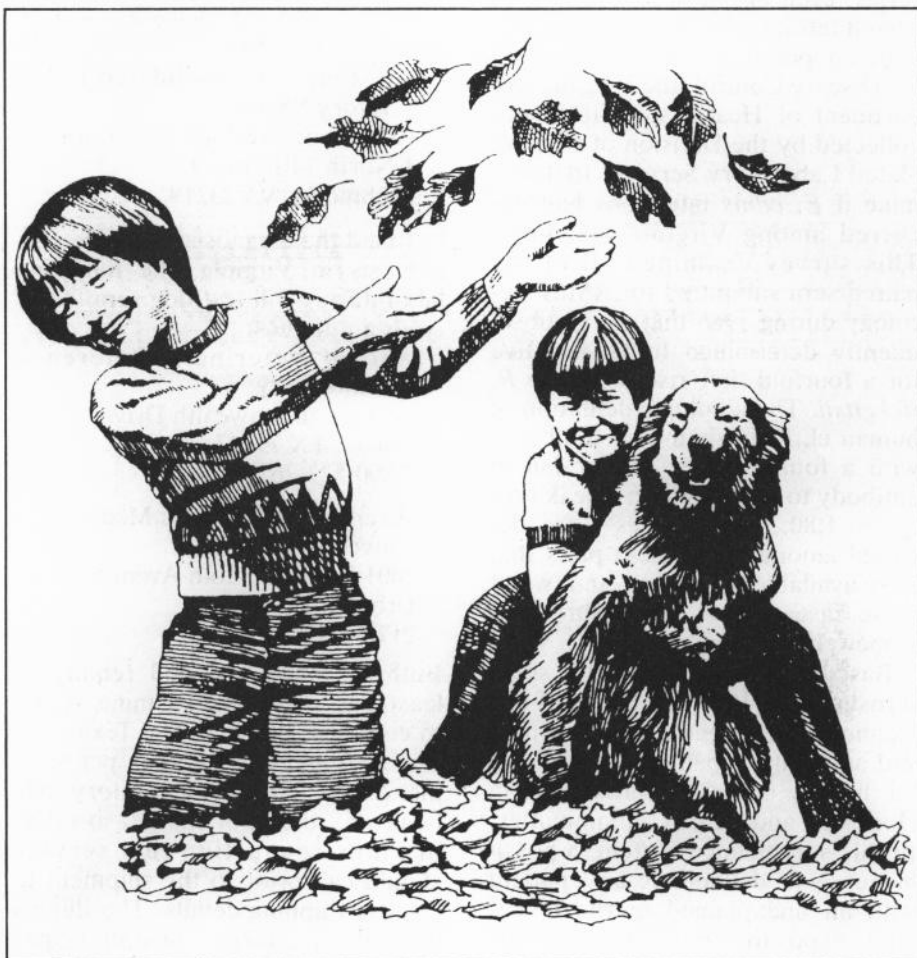
In April 1986, a 51-year-old man was admitted to a Detroit hospital with an acute illness characterized by fever, malaise, myalgia, and headache. Laboratory examination revealed pancytopenia, abnormal liver function tests, and evidence of renal failure (3). Two and one-half weeks prior to admission he had spent time in rural Arkansas planting trees, and had been bitten on the neck by a tick. Although this clinical presentation typified Rocky Mountain spotted fever (RMSF) in its earliest stages, this patient did not develop an exanthem or petechial rash, and did not develop serologic evidence of infection with *Rickettsia rickettsii*. On the seventh day of illness, a peripheral-blood smear revealed occasional blue-staining inclusions in white blood cells, and electron micrographs of these inclusions suggested that they were *Ehrlichia* organisms. Serologic studies to detect antibody to *E. canis* were then performed, and a fourfold fall in titer between convalescent phase and late convalescent phase serum samples was detected, indicating that this acute illness was caused by

E. canis. This patient did recover with chloramphenicol and doxycycline therapy, but since infection with this organism was not initially suspected, no attempt was made to isolate the pathogen from clinical specimens (3).

Prior to this report, *E. canis* was only known to be pathogenic for dogs, and this species was known as the cause of tropical canine pancytopenia. Clinical signs of tropical ca-

nine pancytopenia included fever, lethargy, and bleeding, and hematologic findings included anemia, lymphopenia, thrombocytopenia (4). White blood cell inclusions have not usually been identified in animals infected with *E. canis* (1). Therapeutic response to tetracycline has been noted in infected dogs (5), and canine ehrlichiosis is now known to have worldwide occurrence.

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Because more than three-fourths of humans presenting with clinical illness resembling RMSF may have negative serologic tests for *R. rickettsii* (6), *E. canis* infection in humans may be an unrecognized cause of seronegative "RMSF" in some regions of the United States. Under this premise, the Centers for Disease Control combined active surveillance at a Georgia hospital with a retrospective serosurvey of "RMSF" negative sera from several states to identify cases of human ehrlichiosis. These efforts have resulted in the identification of six more human cases with presumptive serologic evidence of infection with *E. canis* (2). All of the six reported a history of tick bites and fever, and five of the six had leukopenia. None of these patients developed a characteristic rash of spotted fever. Also, none of these cases exhibited white blood cell inclusions, although at the time of illness they were not specifically sought. Recovery was complete in all of the patients in this series, even in one who had not received tetracycline therapy (2).

In cooperation with the Centers for Disease Control, the Virginia Department of Health submitted sera collected by the Division of Consolidated Laboratory Services to determine if *E. canis* infections had occurred among Virginia residents. This survey examined all of the paired sera submitted for RMSF serology during 1986 that were subsequently determined to be negative for a fourfold titer rise or fall to *R. rickettsii*. The serologic definition of human ehrlichiosis included all sera with a fourfold titer rise or fall in antibody to *E. canis* with a peak titer $\geq 1:80$. Three cases were detected among the 13 sera pairs that were available for testing, and two of these cases had tick exposure near Hopewell, Virginia.

Based on the results of this small serosurvey in 1986, the Office of Epidemiology has begun active hospital and ambulatory patient surveillance for human cases of ehrlichiosis in Hopewell and nearby communities. In this surveillance system, a possible case is defined as any patient with an unexplained febrile illness after exposure to ticks. Serologic tests for RMSF will first be per-

formed on these possible cases, and if negative, *E. canis* serology will be performed. Those with a fourfold rise or fall in antibody titer to *E. canis* will be considered cases of human ehrlichiosis in this study, and descriptive clinical and laboratory information will be collected on their illness. Also, all RMSF sera submitted to the Division of Consolidated Laboratory Services in 1987 that are subsequently determined to be negative will be tested for *E. canis* seroconversion. Physicians will be contacted if one of their patients has been found to be a case of human ehrlichiosis through this latter method of passive surveillance, and clinical descriptions of the patient's illness will be sought.

These reports suggest that infection with *Ehrlichia canis* should be considered as a cause of unexplained febrile illness in Virginia residents. We strongly recommend that acute and convalescent sera be obtained on all patients with unexplained febrile illnesses that may be related to tick exposure, and if these tests are negative for RMSF, the submitted sera samples should then be tested for *E. canis* seroconversion. Paired sera for both of these laboratory tests may be sent to:

Division of Consolidated Laboratory Services
Attention: Serology Laboratory
1 North 14th Street
Richmond, VA 23219

To aid the diagnosis of canine ehrlichiosis in Virginia, the following laboratories will test dog sera for *E. canis* antibodies:

Animal Veterinary Reference Laboratory
3191 Commonwealth Drive
Dallas, TX 75247
1-800-527-7673

Veterinary Diagnostic Medicine
University of Illinois
2001 South Lincoln Avenue
Urbana, IL 61801
217-333-2671

Both of these labs will require at least one milliliter of canine serum to complete the test. The Texas laboratory charges 23 dollars per sample. Shipping to this laboratory may be provided free of charge, so veterinarians requesting this service should call prior to the shipment to discuss shipping details. The Illinois laboratory charges 24 dollars per sample, and samples sent to this lab-

oratory should be shipped on ice or "cold pack" if they are not shipped overnight mail.

Since the microbiologic isolation of *Ehrlichia* organisms is still a research tool, we do not presently have the capacity to isolate *E. canis* from clinical specimens. The diagnosis of human ehrlichiosis will rely on the known clinical and epidemiologic findings backed by seroconversion. The Office of Epidemiology is trying to collect information on the distribution and clinical spectrum of all cases of ehrlichiosis in Virginia. To aid us in surveillance, we would appreciate having any information on suspected cases of human and canine ehrlichiosis reported to the Office of Epidemiology, Virginia Department of Health, (804) 786-6261.

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Measles Prevention

These revised recommendations of the Immunization Practices Advisory Committee (ACIP) on measles prevention update the previous recommendations MMWR 1982;31:217-224,229-231) to include current information about vaccine effectiveness and measles elimination efforts. Although there are no basic changes in approach, the statement includes an additional option for outbreak control (revaccination of persons initially vaccinated at 12-14 months of age) and new recommendations for international travelers and medical personnel.

Introduction

Measles (rubeola) is often a severe disease, frequently complicated by middle ear infection or bronchopneumonia. Encephalitis occurs in approximately one of every 2,000 reported cases; survivors often have permanent brain damage and mental retardation. Death, predominantly from respiratory and neurologic causes, occurs in one of every 3,000 reported measles cases. The risk of death is greater for infants and adults than for children and adolescents.

Subacute sclerosing panencephalitis (SSPE) is a "slow virus" infection of the central nervous system associated with measles virus. Widespread use of measles vaccine has led to the virtual disappearance of SSPE from the United States.

Contracting measles during pregnancy increases fetal risk. Most commonly, this risk involves premature labor and moderately increased rates of spontaneous abortion and of low birth weight. One study has suggested that measles infection in the first trimester may induce congenital malformations; confirmatory reports have not been published.

Before measles vaccine was available, more than 400,000 measles cases were reported each year in the United States. However, since virtually all children acquired measles, the true number of cases was probably more than 4 million per year (i.e., the entire birth cohort). Both the type of measles vaccine and the recommended age for measles vaccination have changed several times since 1963, when both an inactivated

and a live, attenuated vaccine (Edmonston B strain) were licensed for use in the United States. The inactivated vaccine was used until 1967, and Edmonston B vaccine, until 1972. A live, further-attenuated Edmonston vaccine was first introduced in 1965 (Schwarz strain), and a similar vaccine (Moraten strain) was licensed in 1968. These further-attenuated vaccines caused fewer reactions than the Edmonston B vaccine yet are equally effective. The Moraten vaccine is the vaccine currently used in the United States.

Because of evidence of increased vaccine efficacy at older ages, the recommended age for vaccination, originally set at 9 months in 1963, was changed to 12 months in 1965 and to 15 months in 1976. Although vaccination is currently recommended at 15 months of age for optimal efficacy, vaccination as early as 12 months of age (on or after the first birthday) is considered appro-

appropriate evidence of measles immunity, and children vaccinated at 12-14 months of age are not routinely revaccinated. Vaccination as early as 6 months of age is recommended in settings of increased risk of disease.

Measles Elimination

Since licensure of vaccine in 1963, the collaborative efforts of professional and voluntary medical and public health organizations in vaccination programs have resulted in a 98%-99% reduction in the reported incidence of measles in the United States. The number of reported measles cases decreased during the late 1960s and early 1970s to between 22,000 and 75,000 cases annually, with incidence rates falling dramatically in all age groups. Children <10 years old had the greatest decline in incidence, whereas older children had a slightly less dramatic de-

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crease. As a result, the proportion of total cases occurring in different age groups changed so that by the period 1976-1980, 46% of cases occurred in children ≥ 10 years of age, compared with the period 1960-1964, when only 9.9% of cases occurred in this age group.

A Measles Elimination Program was announced in 1978, with a goal to eliminate indigenous measles from the United States by October 1, 1982. There are three components of this program: 1) achievement and maintenance of high levels of immunity, 2) effective surveillance of disease, and 3) aggressive outbreak control. As a result of these efforts, the number of cases of measles reported annually dropped from 26,871 in 1978 to approximately 13,500 in 1979 and 1980, to 3,124 in 1981. In 1982, the total fell to 1,714. In 1983, an all-time low of 1,497 reported cases was reached. However, the number of reported cases increased to 2,587 and 2,822, respectively, in 1984 and 1985. During 1986, a provisional total of 6,273 cases were reported.

Since 1984, a classification system has been used to differentiate cases that occurred because of failure to implement the current strategy (preventable cases) from cases that occurred despite appropriate strategy implementation (nonpreventable cases). Of the total cases provisionally reported in 1986, 36.4% were classified as preventable (Table 1). Preschool children 16 months-4 years of age were most likely to have preventable cases (83.2%), whereas

TABLE 1. Total and preventable measles cases, by age group—United States, 1986*

Age Group	Total Cases	Preventable	
		No.	(%)
<16 months	1,229	0	(0.0)
16 months-4 years	1,225	1,019	(83.2)
5-19 years	3,156	927	(29.4)
20-29 years	460	332	(72.2)
≥ 30 years	166	0	(0.0)
Unknown	19	0	(0.0)
Total	6,255[†]	2,278	(36.4)

*Provisional data.

[†]Cases with known preventability status.

only 29.4% of cases in school-aged children (5-19 years of age) were considered preventable. The greatest reason for nonpreventability was a history of previous measles vaccination on or after the first birthday (Table 2). These vaccine failures accounted for 59.8% of the nonpreventable cases and 38.0% of the total reported cases.

In the past several years, most of the outbreaks have occurred in school settings; in 1986, however, several large outbreaks involved communitywide transmission, primarily among unvaccinated preschool-aged children.

Impediments to Measles Elimination

Despite the great success achieved to date in reducing the occurrence of measles in the United States, the goal of eliminating indigenous measles has not yet been reached. Part of the problem is failure to implement the current strategy. Preventable cases (i.e., those in unvaccinated persons) account for approximately one-third of all cases. The age group with the largest proportion of preventable cases is the preschool group.

Children at this age may not yet be enrolled in institutions covered by day-care or school-entry immunization requirements.

A substantial proportion of cases occur among persons who have previously received vaccine. Theoretically, vaccine failures may be primary (the person never developed an adequate immune response to vaccination) or secondary (the person initially developed an adequate response but lost immunity over time). Some of the reported vaccine failures may be among persons whose records incorrectly indicate that they were properly vaccinated. Measles vaccine is at least 95% effective in children vaccinated at ≥ 15 months of age. However, efficacy may be slightly lower in persons vaccinated between 12 and 14 months of age, presumably because transplacental maternal antibody may persist beyond the first birthday in some children and interfere with effective immunization. There are no data to indicate that waning immunity of clinical importance is occurring after measles vaccination.

Another problem is importation of measles from outside the United States. Although importations account for a small proportion of cases (2%), they have initiated several outbreaks and, in some parts of the United States, may be responsible for more measles cases than the number indicated by available surveillance data.

Augmentation of Measles Elimination Activities

The Committee considered, in detail, current measles epidemiology and the measles elimination strategy, as well as potential modifications. It concluded that the current strategy needed more complete implementation to ensure that vaccina-

TABLE 2. Measles cases, by preventability status—United States, 1986*

Classification	No.	(%)
Nonpreventable Cases		
Too young (<16 months)	1,230	(19.7)
Too old (born before 1957)	194	(3.1)
History of vaccination [†]	2,377	(38.0)
Importation by non-U.S. citizen	48	(0.8)
Exemption [§]	128	(2.0)
Subtotal	3,977	(63.6)
Preventable Cases	2,278	(36.4)
Total	6,255	

*Provisional data.

[†]Vaccinated on or after the first birthday.

[§]Includes medical, religious, and philosophic exemptions.

[¶]Cases with known preventability status.

tion takes place at 15 months of age rather than being delayed, for example, until it is required for school entry.

After consideration of possible modifications of the measles elimination strategy, including administering two doses, lowering the age for vaccination, and routinely revaccinating those vaccinated between 12 and 14 months of age, the Committee determined that no change in the routine policy is indicated at present. Continued careful observation and analysis of measles epidemiology is indicated so that any necessary change in strategy can be implemented.

Measles Virus Vaccine

Live measles virus vaccine,* available in the United States, is prepared in chick embryo cell culture. It is available in monovalent (measles only) form and in combinations: measles-rubella (MR) and measles-mumps-rubella (MMR) vaccines. All vaccines containing measles virus are recommended for use at 15 months of age under routine conditions. MMR is the vaccine of choice for routine vaccination programs. In all situations in which measles vaccine is to be used, a combination vaccine should be given if recipients are likely to be susceptible to rubella and/or mumps as well as to measles. There is no harm in revaccinating persons already immune to any of the components of MMR vaccine.

Measles vaccine produces a mild or inapparent noncommunicable infection. Measles antibodies develop in at least 95% of susceptible children vaccinated at ≥ 15 months of age. Both serologic and epidemiologic evidence extending through 23 years indicates that, although the titers of vaccine-induced antibody are lower than those following natural disease, the protection conferred appears to be durable.

Vaccine Shipment and Storage

Vaccine that has been improperly stored may not provide protection against measles. Although data indicate that current measles vaccine may be more thermostable than vaccine produced in the past, it should be kept at 2 C-8 C (35.6 F-46.4 F) or colder during storage. It must also be protected from light, which may

inactivate the virus. Vaccine must be shipped at 10 C (50 F) or colder and may be shipped on dry ice.

Vaccine Usage

General Recommendations

Persons are considered immune to measles only if they have documentation of 1) adequate immunization with live measles vaccine on or after the first birthday, 2) physician-diag-



nosed measles, or 3) laboratory evidence of measles immunity.

Most persons born before 1957 are likely to have been naturally infected and generally need not be considered susceptible. All other children, adolescents, and adults are considered susceptible and should be vaccinated if there are no contraindications (see **Precautions and Contraindications**). This includes persons who may be immune to measles but who lack adequate documentation of immunity. A parental report of immunization, by itself, is not considered adequate documentation. A physician should not provide an immunization record for a patient unless he/she has administered the vaccine or has seen a record documenting vaccination.

The most commonly used laboratory test for assessing immunity to measles has been the hemagglutination-inhibition (HI) test. Other sensitive assays, such as the enzyme immunoassay (EIA), are now being used by many laboratories. Probably most, if not all, persons with detectable antibody are immune. Routine serologic screening to determine measles immunity is not recommended.

Dosage

A single dose of live measles vaccine (as a monovalent or combination product) should be given subcutaneously in the volume specified by the manufacturer. There is no need for a "booster" dose of vaccine if vaccine is given on or after the first birthday.

Age at Vaccination

Measles vaccine is indicated for persons susceptible to measles, regardless of age, unless otherwise contraindicated (see below). Current evidence indicates that for a maximum seroconversion rate, measles vaccine should be given when children are ≥ 15 months of age. Because cases continue to occur in preschool children, increased emphasis must be placed on vaccinating children promptly at 15 months of age. It is particularly important to vaccinate young children ≥ 15 months of age before they might encounter measles in day-care centers or other environments where young children cluster.

The risk of complications from measles is high among infants < 1 year of age. Therefore, considering the benefits and risks, the Committee recommends that infants as young as 6 months of age should be vaccinated with monovalent measles vaccine when exposure to natural measles is considered likely. Because infants vaccinated before the first birthday have a significantly lower rate of seroconversion, they should be revaccinated when they are 15 months old to ensure protection.

Revaccination of Persons Vaccinated According to Earlier Recommendations

Previous vaccination with live vaccine: Persons vaccinated with live measles vaccine before their first birthday should be identified and revaccinated. Some serologic studies show lower seroconversion and seroprevalence rates in children vaccinated between 12 and 14 months of age (80%-95%) than in those vaccinated at ≥ 15 months ($> 95\%$). Many outbreak investigations have also found higher attack rates in persons vaccinated between 12 and 14 months of age than in those vaccinated at ≥ 15 months of age. However, a few other studies have not found a difference. Between 1965 and 1976, the recommended age for
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*Official name: measles virus vaccine, live attenuated.

vaccination in the United States was 12 months; therefore, a large proportion of persons who are between 10 and 21 years of age in 1987 are likely to have been vaccinated when they were between 12 and 14 months of age. Because the vast majority of persons vaccinated between 12 and 14 months of age are fully protected against measles, routine revaccination of such persons is not warranted. However, if revaccination is requested, there is no immunologic or safety reason to deny the request. In an outbreak setting, such revaccination may be useful. (See **Outbreak Control.**)

Edmonston B vaccine was effectively administered with immune globulin (IG). However, the immune response to further-attenuated measles vaccine strains may be impeded by IG. Therefore, the Committee recommends that persons who received measles vaccine of unknown type or further-attenuated measles vaccine accompanied by IG should be revaccinated.

Previous vaccination with killed vaccine or vaccine of unknown type: Some persons who have received inactivated vaccine are at risk of contracting a severe atypical measles syndrome when exposed to the natural virus. Consequently, persons vaccinated at any age with inactivated vaccine (available in the United States from 1963 to 1967) and persons vaccinated with inactivated vaccine followed by live vaccine within 3 months should be revaccinated. Revaccination is particularly

important when the risk of exposure to natural measles virus is increased, for example, during foreign travel.

A wide range (4%–55%) of prior recipients of killed measles vaccine who were revaccinated with live measles vaccine have reportedly had adverse reactions to the live vaccine. Most of these reactions have been mild, consisting of local swelling and erythema, with or without low-grade fever lasting 1–2 days. Rarely, more severe reactions, including prolonged high fevers and extensive local reactions requiring hospitalization, have been reported. However, prior recipients of killed measles vaccine are more likely to have serious illness when exposed to natural measles than when given live measles virus vaccine.

These same recommendations for revaccination apply to persons vaccinated between 1963 and 1967 with a vaccine of unknown type, since their only vaccination may have been with inactivated vaccine. Because killed measles vaccine was not distributed in the United States after 1967, persons vaccinated after 1967 with a vaccine of unknown type need not be revaccinated if the original vaccination occurred on or after the first birthday and was not accompanied by IG.

Individuals Exposed to Disease

Use of vaccine: Exposure to measles is not a contraindication to vaccination. Available data suggest that live measles vaccine, if given within 72 hours of measles exposure, may provide protection and is preferable to the use of IG in persons at least 12 months of age if there is no contraindication. If the exposure does

not result in infection, the vaccine should induce protection against subsequent measles infection.

Use of IG: IG can be given to prevent or modify measles in a susceptible person within 6 days after exposure. The recommended dose of IG is 0.25 ml/kg (0.11 ml/lb) of body weight (maximum dose = 15 ml). IG may be especially indicated for susceptible household contacts of measles patients, particularly contacts under 1 year of age, pregnant women, or immunocompromised persons, for whom the risk of complications is highest. The recommended dose of IG for immunocompromised persons is 0.5 ml/kg of body weight (maximum dose = 15 ml). If the individual is at least 15 months old and there is no contraindication to vaccination, live measles vaccine should be given 3 months later, by which time the passively acquired measles antibodies should have disappeared. IG should not be used to control measles outbreaks.

Side Effects and Adverse Reactions

Experience with more than 160 million doses of measles vaccine distributed in the United States through 1986 indicates an excellent record of safety. From 5% to 15% of vaccinees may develop a temperature of ≥ 103 F (≥ 39.4 C) beginning about the fifth day after vaccination and usually lasting several days. Most persons with fever are otherwise asymptomatic. Transient rashes in approximately 5% of vaccinees have been reported. Central nervous system conditions including encephalitis and encephalopathy have been reported with a frequency of less than one case per million doses administered. The incidence rate of encephalitis or encephalopathy following measles vaccination is lower than the observed incidence rate of encephalitis of unknown etiology, suggesting that some or most of the reported severe neurologic disorders may be only temporally related to measles vaccination rather than due to vaccination. Limited data indicate that reactions to the vaccine are not age related.

Personal and Family History of Convulsions

As with the administration of any agent that may produce fever, some children may have a febrile seizure



following measles vaccination. Although children with a personal or family history of seizures are at increased risk for developing idiopathic epilepsy, febrile seizures—including those following vaccinations—do not, in and of themselves, increase the probability of subsequent epilepsy or other neurologic disorders. Most convulsions following measles-containing vaccines are simple febrile seizures, and they occur in children without known risk factors. Recent data suggest that there is an increased risk of these convulsions among children with a prior history of convulsions or those with a history of convulsions in first-degree family members (i.e., siblings or parents). Although the precise risk cannot be determined, it appears to be low.

In developing vaccination recommendations concerning these children, the Committee considered a number of factors including risks from measles disease, the large number (5%–7%) of children with a personal or family history of convulsions, and the fact that convulsions following measles vaccine are uncommon and have not been associated with permanent brain damage. The Committee concluded that the benefits of immunizing children with a personal history of convulsions or a family history of convulsions in first-degree relatives greatly outweigh the risks. These children should be vaccinated in the same way that children without such histories are vaccinated.

Because the period for contracting vaccine-induced fever begins approximately 5 days after vaccination and lasts approximately 1 week, effective reduction of the risk of a febrile seizure is difficult. Prophylaxis with antipyretics is one alternative, but these agents probably would be ineffective if given after the onset of fever. To be effective, they would have to be given before the expected onset of fever and continued for another 5–7 days. Nevertheless, parents should closely observe children for fever during this period, and if fever occurs, the child should be treated appropriately.

Children who are receiving anti-convulsants should continue to take them after measles vaccination. Because protective levels of most currently available anticonvulsant drugs (e.g., phenobarbital) are not

achieved for some time after the initiation of therapy, prophylactic use of these drugs does not seem feasible.



The parents of children who have either a personal or family history of seizures should be advised that such children have a small increased risk of seizures following vaccination. In particular, they should be told in advance of measles vaccination what to do in the unlikely event that the child has a seizure. The permanent medical record should document that the small risk of postvaccination seizures and the benefits of vaccination for these children have been discussed.

Revaccination Risks

There is no evidence of enhanced risk from receiving live measles vaccine to persons who are already immune to measles, either from vaccination or natural disease. (See **Previous vaccination with killed vaccine or vaccine of unknown type.**)

Precautions and Contraindications

Pregnancy

Live measles vaccine should not be given to women known to be pregnant or who are considering becoming pregnant within 3 months after vaccination. This precaution is based on the theoretical risk of fetal infection, which applies to the administration of any live virus vaccine to women who might be pregnant or

who might become pregnant shortly after vaccination. No evidence exists to substantiate this theoretical risk from measles vaccine. Considering the importance of protecting adolescents and young adults against measles with its known serious risks, asking women if they are pregnant, excluding those who are, and explaining the theoretical risks to the others before vaccination are the recommended precautions in a measles immunization program.

Febrile Illness

Vaccine administration should not be postponed because of minor illnesses, such as mild upper-respiratory infections. However, vaccination of persons with severe febrile illnesses should generally be deferred until they have recovered. Considering the importance of measles protection, medical personnel should use every opportunity to vaccinate susceptible children.

Allergies

Hypersensitivity reactions following the administration of live measles vaccine are rare. Most of these reactions are minor and consist of wheal and flare or urticaria at the injection site. With more than 160 million doses of measles vaccine distributed in the United States, there have been at least five reported cases of immediate allergic reactions in children who had histories of anaphylactic reactions to egg ingestion. These reactions to vaccine could potentially have been life threatening. Four children experienced difficulty in breathing; one of these had hypotension. Persons with a history of anaphylactic reactions following egg ingestion (hives, swelling of the mouth and throat, difficulty in breathing, hypotension, or shock) should be vaccinated only with extreme caution. Protocols have been developed for vaccinating such persons (1). Evidence indicates that persons are not at increased risk if they have egg allergies that are not anaphylactic in nature. Such persons should be vaccinated in the usual manner. There is no evidence that persons with allergies to chickens or feathers are at increased risk of reaction to the vaccine.

Since measles vaccine contains trace amounts of neomycin (25µg), persons who have had anaphylactic reactions to topically or systemically administered neomycin should not

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Measles Prevention (Continued from page 7)

receive measles vaccine. Most often, neomycin allergy is manifested as a contact dermatitis that is a delayed-type (cell-mediated) immune response rather than anaphylaxis. In such individuals the adverse reaction, if any, to 25 μ g of neomycin in the vaccine would be an erythematous, pruritic nodule or papule at 48–96 hours. A history of contact dermatitis to neomycin is not a contraindication to receiving measles vaccine. Live measles virus vaccine does not contain penicillin.

Recent Administration of IG

Vaccination should be deferred for 3 months after a person has received IG, whole blood, or other antibody-containing blood products because passively acquired antibodies might interfere with the response to the vaccine. If vaccine is given to a person who has received such products within the preceding 3 months, the person should be revaccinated. If IG is to be administered in preparation for international travel, administration of vaccine should precede IG by at least 2 weeks.

Tuberculosis

Tuberculosis may be exacerbated by natural measles infection. There is no evidence that the live measles virus vaccine has such an effect. Tuberculin skin testing is not a prerequisite for measles vaccination. If tuberculin testing is needed, it can be done the day of vaccination. Other-

wise, it is prudent to wait 4–6 weeks after measles immunization before administering a tuberculin skin test, since measles vaccination may temporarily suppress tuberculin reactivity.

Altered Immunity

Replication of the measles vaccine virus may be potentiated in patients with immune deficiency diseases and by the suppressed immune responses that occur with leukemia, lymphoma, generalized malignancy, acquired immunodeficiency syndrome (AIDS), or with certain therapies (corticosteroids, alkylating drugs, antimetabolites, or radiation). Patients with such conditions should not be given live measles virus vaccine. Since vaccinated persons do not transmit vaccine virus, the risk to these patients of being exposed to measles may be reduced by vaccinating their close susceptible contacts. Management of such persons, should they be exposed to measles, can be facilitated by prior knowledge of their immune status. If susceptible, they should receive IG following exposure (see below).

Patients with leukemia in remission whose chemotherapy has been terminated for at least 3 months may receive live virus vaccines. Persons infected with the human immunodeficiency virus (HIV) who are asymptomatic also can receive measles vaccine (2). Short-term corticosteroid therapy (<2 weeks), topical steroid therapy (e.g., nasal, skin), and intraarticular, bursal, or tendon

injection with corticosteroids should not be immunosuppressive and do not contraindicate measles vaccine administration. However, measles vaccine should be avoided if systemic immunosuppressive levels are reached by prolonged, extensive, topical application.

Management of Patients with

Contraindications to Measles Vaccine

If immediate protection against measles is required for persons for whom measles vaccine is contraindicated, passive immunization with IG, 0.25 ml/kg (0.11 ml/lb) of body weight, should be given as soon as possible after known exposure (maximum dose = 15 ml). It is important to note, however, that IG in usual doses may not be effective in children with acute leukemia or other conditions associated with altered immunity. Consequently, for immunocompromised persons, the recommended dose of IG is 0.5 ml/kg of body weight (maximum dose = 15 ml).

Simultaneous Administration of Vaccines

Simultaneous administration of MMR, oral poliovirus vaccine (OPV), and diphtheria and tetanus toxoids and pertussis (DTP) vaccines results in seroconversion rates and rates of side effects similar to those observed when the vaccines are administered separately. On the basis of these results, the Committee recommends routine administration of MMR, OPV, and DTP simultaneously to susceptible persons at 15 months of age (3). Some health-care providers may prefer to continue administering MMR at 15 months of age, followed by DTP and OPV at 18 months of age, especially for patients who are known to be compliant with health-care recommendations.

Ongoing Programs

The best means of reducing the incidence of measles is by having an immune population. Programs aimed at vaccinating children against measles at 15 months of age should be established and maintained in all communities. In addition, all other persons thought to be susceptible, regardless of age, should be vaccinated when they are identified, unless vaccine is otherwise contraindicated.





Official health agencies should take whatever steps are necessary, including development and enforcement of school immunization requirements, to achieve and maintain high immunization levels. Most states currently require evidence of immunity to measles for children enrolled in day-care centers. Enforcement of such requirements has been correlated with reduced measles incidence rates.

Vaccination for College Entry

Measles outbreaks continue to be reported from settings where young adults are concentrated, such as colleges. Measles control in these places requires careful evaluation of susceptibility and vaccination of those who are susceptible. The Committee recommends that colleges and universities require proof of measles immunity as a condition for matriculation.

Vaccination for Medical Personnel

Medical personnel are at higher risk for acquiring measles than the general population. Medical facilities should ensure that all employees born after 1956 have proof of immunity (See **Vaccine Usage**). Since a substantial proportion of medical personnel who have acquired measles were born before 1957, medical facilities may also consider requiring proof of measles immunity for older employees who may have occupational exposure to measles.

Outbreak Control

All reports of suspected measles cases should be investigated rapidly. A measles outbreak exists in a community whenever one case of measles is confirmed. Once an outbreak occurs, preventing dissemination of measles depends on promptly vaccinating susceptible persons. Control activities should not be delayed until laboratory results on suspected cases are received. All persons who cannot readily provide proof of immunity should be vaccinated or excluded from the setting (e.g., school). Documentation of vaccination should be considered adequate only if the date of vaccination is provided.

An effective means of terminating school outbreaks and quickly increasing rates of immunization is to exclude all children or adolescents from the outbreak area who cannot present valid evidence of immunity. Students can be readmitted immediately after vaccination. Experience with outbreak control indicates that almost all students who are excluded from the outbreak area because they lack evidence of immunity to measles quickly comply with requirements and can be readmitted to school. Pupils who have been exempted from measles vaccination because of medical, religious, or other reasons should be excluded until at least 2 weeks after the onset

of rash in the last person with measles in the outbreak area.

Persons vaccinated between 12 and 14 months of age have been shown in some serologic and epidemic investigations to be at increased risk of acquiring measles compared with those vaccinated at ≥ 15 months of age. However, the increased risk of acquiring measles is small. Nevertheless, in many outbreaks, particularly in junior and senior high schools, persons vaccinated at 12–14 months of age appear to have played a substantial role in perpetuating transmission. Therefore, although the effectiveness of such a strategy in terminating outbreaks has not been demonstrated conclusively, the Committee recommends that revaccination of persons vaccinated at 12–14 months of age should be considered in outbreak settings, particularly in junior and senior high schools. If revaccination is recommended, local officials should establish a geographic zone of risk and limit revaccination to persons in this area. In the absence of an outbreak, routine revaccination of persons vaccinated at 12–14 months of age is not recommended.

Importations

Measles importations are a continuing source of reported measles cases in the United States. Although most importations result in limited transmission, several large outbreaks have occurred. If susceptible persons are exposed to a patient on a common carrier, such as an airplane, rapid reporting of such imported cases to state and local health departments is important. Other state health departments should be notified to identify exposed contacts as well as to initiate surveillance and control measures.

Surveillance

As the incidence rate of measles declines in the United States, aggressive surveillance becomes increasingly important. Known or suspected measles cases should be reported immediately to local health departments. Serologic confirmation should be attempted for every suspected case of measles that cannot be linked to a confirmed case. Reporting of suspected cases and implementation of outbreak-control activities should not be delayed while awaiting laboratory results. Effective

(Continued to page 10)

Measles Prevention (Continued from page 9)

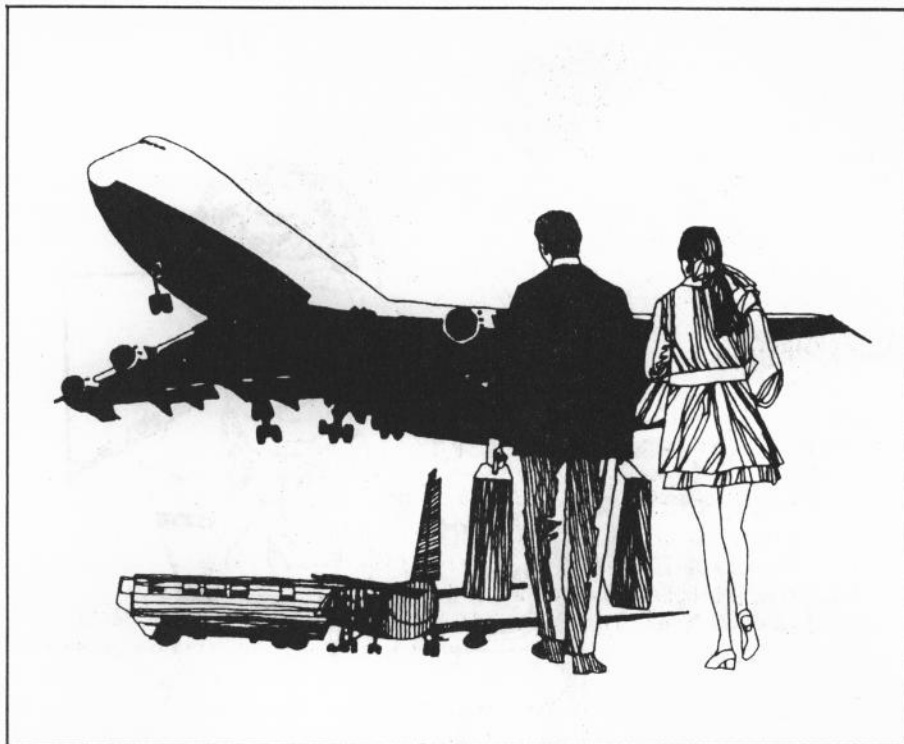
tive surveillance of measles and its complications can delineate inadequate levels of protection, further define groups needing special attention, and assess the effectiveness of control activities.

Continuous and careful review of adverse events following measles vaccination is also important. All adverse events following vaccination should be evaluated and reported in detail to local and state health officials as well as to the vaccine manufacturer.

Laboratory Diagnosis

The traditional serologic diagnosis of measles requires a significant rise in antibody titer between the acute-phase and convalescent-phase serum specimen. However, a single specimen can be used to detect the presence of immunoglobulin M (IgM) antibody. Correct interpretation of serologic data depends on the proper timing of specimen collection in relation to onset of rash. This is especially important for interpreting negative IgM results, since IgM antibody peaks 10 days after rash onset and is usually undetectable 30 days after rash onset.

Asymptomatic reinfection with measles virus can occur in persons who have previously developed antibody, whether from vaccination or from natural disease. Symptomatic reinfections have been reported rarely. These infections have been accompanied by fourfold or greater rises in measles HI antibody titers, but measles-specific IgM antibodies have not been detected in appropriately timed serum specimens.



International Travel

Persons traveling abroad should be immune to measles. Since the risk of serious complications and death is greater for adults than for children, it is especially important to protect young adults who have escaped measles and have not been vaccinated. Also, because measles vaccine is not 100% effective and because the risk of exposure to measles abroad may be substantially greater than in the United States, consideration should be given to providing a one-time dose of measles vaccine to persons born after 1956 who travel abroad regardless of their previous vaccination status, unless there is a contraindication. Persons born before 1957 need not be considered susceptible. MMR is preferred for persons likely to be susceptible to mumps and rubella. If single-antigen measles vaccine is not readily available, travelers should receive MMR regardless of their immune status to mumps and rubella.

The age for measles vaccination should be lowered for children traveling to areas where measles is endemic or epidemic. Children 12–14 months of age should receive MMR vaccine before their departure (without need for revaccination). Children 6–11 months of age should receive a dose of single-antigen measles vaccine before departure and subsequently should receive MMR vac-

cine. Whereas the optimal age for revaccination is 15 months, the age for revaccination may be as low as 12 months if the child remains in a high-risk area. Since virtually all infants <6 months of age will be protected by maternally derived antibodies, no additional protection against measles in this age group is generally necessary.

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Reprinted from MMWR 1987;36:409-18, 423-5.



Cases of selected notifiable diseases, Virginia, for the period July 1, through July 31, 1987

Disease	State					Regions				
	This Month	Last Month	Total to Date 1986 1987		Mean 5 Year To Date	This Month				
						N.W.	N.	S.W.	C.	E.
Measles	0	1	57	1	24	0	0	0	0	0
Mumps	10	5	27	66	26	3	1	0	0	6
Pertussis	1	3	20	38	20	0	0	0	0	1
Rubella	0	0	0	1	3	0	0	0	0	0
Meningitis—Aseptic	26	4	108	90	96	5	7	1	1	12
*Bacterial	11	10	155	105	149	0	0	1	1	9
Hepatitis A (Infectious)	10	6	69	154	85	3	0	6	1	0
B (Serum)	41	28	254	263	297	1	2	13	5	20
Non-A, Non-B	8	5	39	32	51	1	4	2	0	1
Salmonellosis	153	194	659	866	725	25	31	18	44	35
Shigellosis	16	12	42	85	78	4	4	5	1	2
Campylobacter Infections	76	57	308	319	289	16	14	10	17	19
Tuberculosis	54	54	206	267	284	9	8	11	7	19
Syphilis (Primary & Secondary)	39	26	219	174	269	1	4	4	17	13
Gonorrhea	1003	1120	10360	8349	11122	—	—	—	—	—
Rocky Mountain Spotted Fever	3	3	24	6	27	1	0	0	2	0
Rabies in Animals	22	46	110	230	222	10	4	1	6	1
Meningococcal Infections	7	6	51	52	46	1	1	1	2	2
Influenza	0	2	3927	1204	1428	0	0	0	0	0
Toxic Shock Syndrome	0	0	6	0	5	0	0	0	0	0
Reyes Syndrome	0	0	2	0	3	0	0	0	0	0
Legionellosis	0	2	8	5	11	0	0	0	0	0
Kawasaki's Disease	3	4	17	17	18	0	0	0	0	3
Acquired Immunodeficiency Syndrome	22	14	102	128	—	0	11	3	2	6

Counties Reporting Animal Rabies: Albemarle 1 fox, 1 raccoon; Augusta 1 fox; Fairfax 2 raccoons; Frederick 1 raccoon; Hanover 1 goat, 2 raccoons; Henrico 1 raccoon; Loudoun 1 skunk, 1 raccoon; Louisa 1 raccoon; New Kent 2 raccoons; Orange 1 skunk; Page 1 skunk; Radford 1 fox; Rockingham 1 horse; Shenandoah 1 beaver; Spotsylvania 1 skunk; Westmoreland 1 raccoon.

Occupational Illnesses: Poisoning, chemical 55; Asbestosis 34; Pneumoconioses 30; Carpal tunnel syndrome 17; Hearing loss 5; Silicosis 1.

*other than meningococcal

Published Monthly by the
VIRGINIA HEALTH DEPARTMENT
 Office of Epidemiology
 109 Governor Street
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